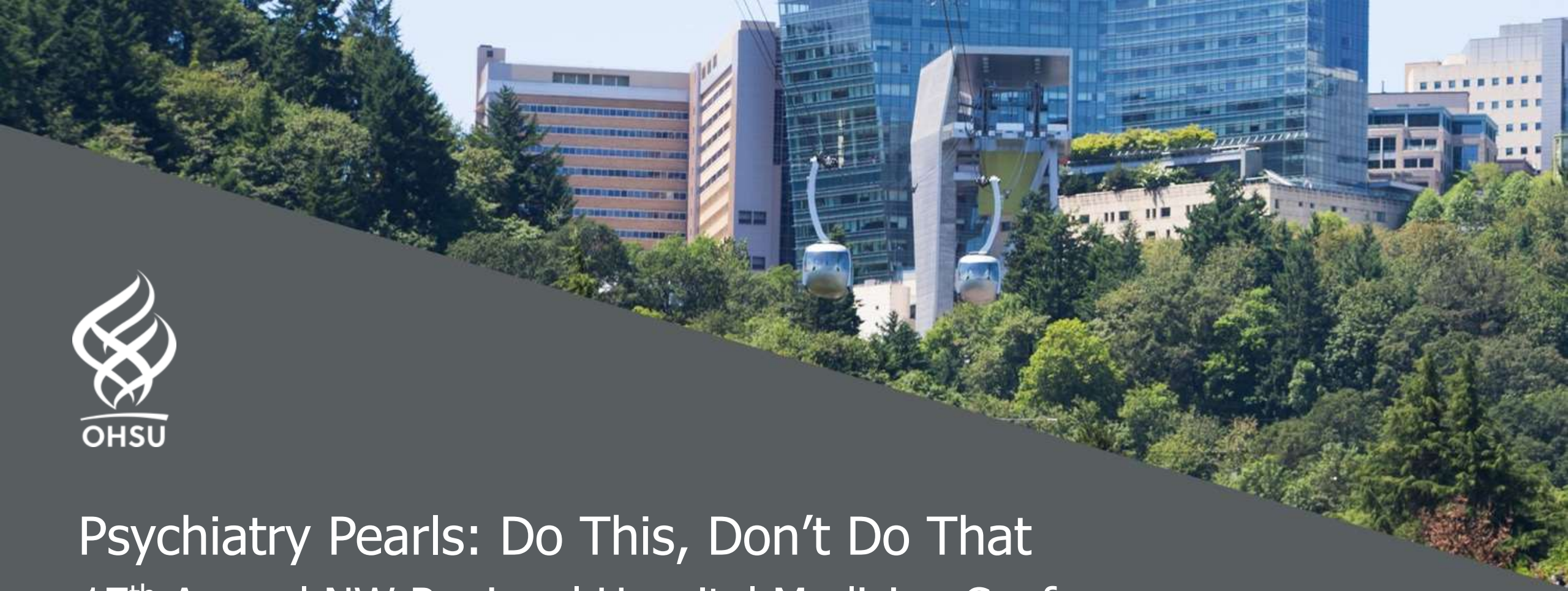

# Psychiatry Pearls: Do This, Don't Do That

## 17th Annual NW Regional Hospital Medicine Conference

DATE: September 23, 2022 PRESENTED BY: Jonathan Floriani, MD, Assistant Professor of Psychiatry

# Disclosures

- I have no actual or potential conflict of interest in relation to this presentation.



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# Learning Objectives

- Describe the overall treatment approach of a psychiatric consultation-liaison team in an inpatient medical setting
- Compare presenting features of common and acute psychiatric disorders in inpatient medical settings
- Evaluate acute psychiatric disorders on a spectrum between chronic mental illness and symptoms related to general medical conditions or treatments
- Outline treatment guidelines for management of acute psychiatric symptoms or disorders



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# General Approach

# General Approach

- In acute inpatient medical settings
  - Don't always assume accuracy of chart or self-reported psychiatric diagnoses
  - Do think about reported or observed symptom clusters



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# General Approach

- Accuracy of chart and self-reported diagnoses
- Treatment of general symptoms vs specific diagnosis
  - Exacerbation of symptoms?
- Collateral information and precipitating events
- Acute and chronic medical comorbidities



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# What do clinicians treat: diagnoses or symptoms? The incremental validity of a symptom-based, dimensional characterization of emotional disorders in predicting medication prescription patterns

Monika A Waszczuk[1], Mark Zimmerman[2], Camilo Ruggero[3], Kaiqiao Li[1], Annmarie MacNamara[4], Anna Weinberg[5], Greg Hajcak[6], David Watson[7], and Roman Kotov[1]

Waszczuk MA, Zimmerman M, Ruggero C, et al. What do clinicians treat: Diagnoses or symptoms? The incremental validity of a symptom-based, dimensional characterization of emotional disorders in predicting medication prescription patterns. *Compr Psychiatry*. 2017;79:80-88. doi:10.1016/j.comppsych.2017.04.004

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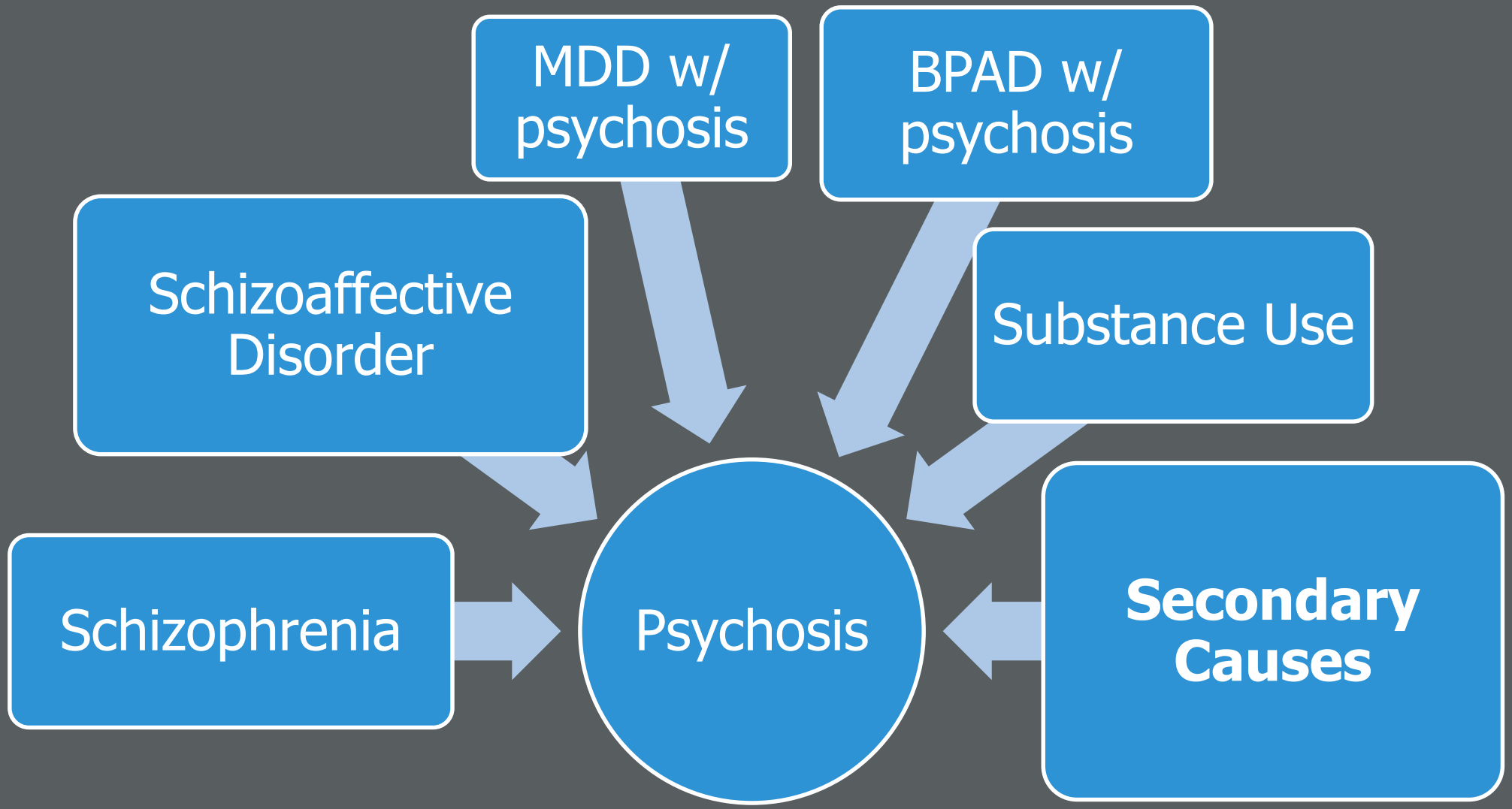
MDD w/ psychosis
BPAD w/ psychosis
Schizoaffective Disorder
Substance Use
Schizophrenia
Psychosis
Secondary Causes



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# Acute Psychosis

# Acute Psychosis

- Don't assume all odd or illogical behavior is related to psychosis
  - Illusions vs hallucinations
  - Over-valued ideas/thoughts vs delusions
  - Certain personality traits (paranoid, borderline, schizotypal) *"micro-psychosis"*
- Do remember that psychosis isn't just hallucinations or delusions



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# Psychosis: "A disconnection from reality

## Delusions

- Fixed, false beliefs
- Persecutory, somatic, religious, grandiose
- Bizarre vs. Non-bizarre

## Hallucinations

- Perception without external stimuli
- Illusions with external stimuli
- Can be normal

## Disorganization

- Behavior vs. Thinking
- Associations and rate

Schizophrenia spectrum and other psychotic disorders. DSM Library. https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425596.dsm02. Accessed January 29, 2022.

# Acute Psychosis

- Catatonia
- Negative Symptoms



Schizophrenia spectrum and other psychotic disorders. DSM Library. https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425596.dsm02. Accessed January 29, 2022.

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# Acute Psychosis

- Causes
  - Primary: Schizophrenia, Schizoaffective, etc.
  - Secondary: Not primary ☺
    - Usually encephalopathy/delirium but can persist/become chronic
    - Encephalitis (autoimmune vs. infectious)
    - Neurodegenerative diseases
    - Metabolic conditions
    - Substances (including medications)



Calabrese J, Al Khalili Y. Psychosis. [Updated 2021 Jul 19]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK546579/

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# Acute Psychosis

- Substance induced causes
  - Alcoholic hallucinosis vs withdrawal delirium
    - Similar to benzodiazepine withdrawal
  - Anabolic and corticosteroids
  - Anticholinergic medications
  - Antidepressants
    - Can cause “manic switch” which may appear psychotic
  - Hallucinogens, Inhalants, **Stimulants**, Toxins, among many others!

# Acute Psychosis

- Don't assume that psychosis caused secondarily will improve at the same rate
- Do continue to monitor/track symptoms
  - Refer for close follow-up if there are residual symptoms at discharge
  - Especially for younger patients



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# Acute Psychosis

- What manifestations do we manage acutely?
  - Agitation/aggression
  - Catatonia

# Acute Psychosis

- Management of Aggression/Agitation
  - Nonpharmacologic
  - Pharmacologic
    - First-Generation antipsychotics
    - Second-Generation antipsychotics
    - Benzodiazepines
    - Does not always address underlying cause of agitation (especially in delirium, or neurocognitive disorders)



Wilson, Michael & Pepper, David & Currier, Glenn & Holloman, Garland & Feifel, David. (2012). The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. The western journal of emergency medicine. 13. 26-34. 10.5811/westjem.2011.9.6866.

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# Acute Psychosis

- Don't necessarily think of treatment as a "chemical restraint"
- Do target symptoms/cause with treatment that is "usual and customary"
- Do try to work with patients prior to agitation to select preferred medications
- Do try to use PO over IV/IM if possible



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# Acute Psychosis

- Project BETA Algorithm
  - Agitation due to
    - Delirium
    - ETOH or benzodiazepine withdrawal
    - Intoxication
    - Primary psychosis



Wilson, Michael & Pepper, David & Currier, Glenn & Holloman, Garland & Feifel, David. (2012). The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. The western journal of emergency medicine. 13. 26-34. 10.5811/westjem.2011.9.6866.

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# Acute Psychosis

- First-Generation Antipsychotics
  - Inhibition of dopamine transmission through D2 blockade
  - Modulates GABA receptors
    - May be calming when source is not necessarily primary in etiology



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# Acute Psychosis

- First-Generation Antipsychotics
  - Chlorpromazine/Thorazine
    - Not preferred
  - Haloperidol/Haldol
    - Most preferred due to PO/IM/IV route
  - Droperidol
    - Similar to Haldol in effect, used commonly in anaesthesia or antiemetic



Wilson, Michael & Pepper, David & Currier, Glenn & Holloman, Garland & Feifel, David. (2012). The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. The western journal of emergency medicine. 13. 26-34. 10.5811/westjem.2011.9.6866.

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# Acute Psychosis

- Second-Generation Antipsychotics
  - As a class, preferred over first-generation antipsychotics
  - Block D2, but also act at 5-HT2A receptors.
    - Also histamine, NE, and alpha-2
  - Lower risk of dystonia, NMS, akathisia



Wilson, Michael & Pepper, David & Currier, Glenn & Holloman, Garland & Feifel, David. (2012). The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. The western journal of emergency medicine. 13. 26-34. 10.5811/westjem.2011.9.6866.

# Acute Psychosis

- Second-Generation Antipsychotics
  - Do think about Olanzapine as first-line treatment
  - Don't use IV formulation outside of ICU/ED, don't use parenteral olanzapine with parenteral benzodiazepine



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# Acute Psychosis

- Second-Generation Antipsychotics
  - Ziprasidone
    - PO/IM
    - PO form not usually helpful in acute settings due to bioavailability limitations
    - IM used in emergency situations, usually combined with benzodiazepine
      - Typically 20 mg of ziprasidone with 2 mg of lorazepam, NTE 40 mg/24 hours



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# Acute Psychosis

- Second-Generation Antipsychotics
  - Quetiapine
    - PO only
    - Helpful in outpatient settings, less so for acute agitation
    - Low doses mainly target histamine and alpha receptors
      - Risks of orthostasis, does not target many mechanisms of agitation

# Acute Mania

# Acute Mania

| | | |
|---|---|---|
| Elevated Mood | Grandiosity | Decreased need for sleep |
| Talkativeness | Flight of Ideas | Distractibility |
| Goal Directed Activity | High Risk Behaviors | Impaired Social Functioning |

Bipolar and Related Disorders. DSM Library. https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm03. Accessed January 29, 2022.

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# Acute Mania

- Do think about similar primary causes for mania as psychosis
  - Especially psychostimulant use
  - Hyperactive delirium
  - Post-partum psychosis is treated like mania
- Don't ignore suicide or violence risk in patients with acute mania



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# Acute Mania

- In acute medical settings
  - Do use a 2nd generation AP
  - Don't start a mood stabilizer right away!

# Acute Mania

- General approach
  - Recommended to start SGA + mood stabilizer in acute *psychiatric* settings
    - Many drawbacks to this in emergency/medical settings!
  - Continue combined therapy for 6 months then discontinue SGA if stable



Vieta E, Sanchez-Moreno J. Acute and long-term treatment of mania. *Dialogues Clin Neurosci*. 2008;10(2):165-179. doi:10.31887/DCNS.2008.10.2/evieta

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# Acute Mania

- Treatment
  - Antipsychotics
    - Olanzapine, risperidone, quetiapine, ziprasidone, chlorpromazine, aripiprazole
    - Similar dosing to acute psychosis
    - Quick onset to mitigate most dangerous symptoms
  - Lithium
    - In combination with antipsychotic (more effective than each alone)
    - Less helpful in emergency settings with many other drawbacks
  - Valproic Acid
    - Can be better tolerated than lithium and well-documented effect over 1-2 weeks



Vieta E, Sanchez-Moreno J. Acute and long-term treatment of mania. *Dialogues Clin Neurosci*. 2008;10(2):165-179. doi:10.31887/DCNS.2008.10.2/evieta

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# Takeaways

# Takeaways

- Think symptom clusters over primary diagnosis
  - Psychosis/Mania vs. Schizophrenia/BPAD
  - Broad range of symptoms!
- Psychosis and mania have many secondary causes
  - Can persist even after cause has improved
- Think of medication for agitation as providing a treatment rather than a restraint
  - Can help to clarify source of agitation “psychotic agitation” “agitation due to delirium”, etc.



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# Thank you!

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or call 503-494-0920